LANCASTER COUNTY

Supplemental Life and Accident Death and Dismemberment Insurance Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name:	**Social Security #:**
Salary:	**Date of Birth:**
Date of Hire:	**Effective Date:**

The following costs should be calculated based on your age as of the effective date.

Supplemental Life/Accidental Death and Dismemberment Insurance - Employee

You have the opportunity to enroll in Lancaster County's Supplemental Life/Accidental Death and Dismemberment Insurance plan. Your election may be made in increments of $10,000, not to exceed 5 times your salary or $500,000, whichever is less. If you elect an amount that exceeds the guaranteed issue amount of $250,000, you will need to provide evidence of good health that is satisfactory to Hartford Life before the excess can become effective. ***You must complete the Beneficiary Designation section below.***

Use the rate chart and calculation line below to determine your (12) Monthly cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.110	$0.110	$0.120	$0.150	$0.200	$0.300	$0.480	$0.720	$1.070	$1.930	$3.340	$5.490

☐ I elect to **enroll** in the Supplemental Life/AD&D plan at the (12) Monthly cost below.*

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount | Rate Above | Your (12) Monthly Cost*

☐ I elect to **decline** the Supplemental Life/ AD&D plan.

*Your cost may change if your age category changes within the benefits plan year.

*Note: Benefit reductions begin at age 70. Please see your benefits administrator for further information.

Supplemental Life/Accidental Death and Dismemberment Insurance - Spouse

If you elect the Supplemental Life/Accidental Death and Dismemberment plan for yourself, you may elect Supplemental Life/Accidental Death and Dismemberment coverage for your Spouse. Your election may be made in increments of $5,000 to a maximum of $100,000 but may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of $50,000, your Spouse will need to provide evidence of good health that is satisfactory to Hartford Life before the excess can become effective. **Supplemental Spouse rates and premiums are based on the Spouse's age, not the Employee's age.**

Use the rate chart and calculation line below to determine your (12) Monthly cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.110	$0.110	$0.120	$0.150	$0.200	$0.300	$0.480	$0.720	$1.070	$1.930	$3.340	$5.490

☐ I elect to **enroll** my Spouse in the Supplemental Life/AD&D plan at the (12) Monthly cost below.*

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount | Rate Above | Your (12) Monthly Cost*

☐ I elect to **decline** the Supplemental Life/AD&D plan for my Spouse.

*Your cost may change if your Spouse's age category changes within the benefits plan year.

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth

Supplemental Life/Accidental Death and Dismemberment Insurance - Child(ren)

If you elect the Supplemental Life/Accidental Death and Dismemberment plan for yourself, you may elect Supplemental Life/Accidental Death and Dismemberment coverage for your Dependent Child(ren) between the ages of 2 weeks to 19 years (25 years if a full time student). Your election may be made in increments of $1,000 to a maximum of $10,000 at the cost per child below. Use the rate chart and calculation line to determine your (12) Monthly cost for this coverage.

Child Life Amount	$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
Cost per Child	$0.140	$0.280	$0.420	$0.560	$0.700	$0.840	$0.980	$1.120	$1.260	$1.400

☐ I elect to **enroll** my dependent child(ren) in the Supplemental Life/AD&D plan for $_____ at the (12) Monthly cost below.

_____ x _____ = $_____

# of Children | Cost Per Child Above | Your (12) Monthly Cost

☐ I elect to **decline** the Supplemental Life/AD&D plan for my dependent child(ren).

CHILD:

First Name	Last Name	Gender	Date of Birth	Benefit Amount

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in Lancaster County's Group Supplemental Life/Accidental Death and Dismemberment Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Signature: _____ **Date:** _____